Statement
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Good afternoon Mr. Chairman, Ranking Member Blumenthal, and members of this distinguished Committee. I am grateful for the opportunity to appear before you this afternoon on behalf of our company's non-profit owners and employees to discuss TriWest Healthcare Alliance's work in implementing the Veterans Choice Program (VCP). More importantly, I look forward to discussing our ability to achieve our collective potential in meeting the needs of those who deserve our very best… our nation's Veterans.

Our Background

TriWest is intentionally in business only to serve those who serve; which has been the case for nearly 20 years. And during our entire history, the company I was fortunate to help found with a group of non-profit health plans and University Hospital Systems, and have been privileged to lead since, has focused exclusively on providing access to needed care when it is not able to be provided by the federal systems on which those in uniform rely. Our first 17 years were spent helping the Department of Defense (DoD) stand-up and operate the TRICARE program. And while we no longer support the DoD in that line of work, I'm proud of the work that we did to assist DoD in making TRICARE the most popular health plan in the country and meet the needs of millions across 21 states who relied on us for that support. And, as those of us who were around at the time can attest, we know it was neither an easy nor painless road. Now, working together with VA, I believe we can achieve the same results for the Veterans who look to VA for their health care needs.

PC3 Performance

Mr. Chairman, before VCP, there was PC3.

In September 2013, TriWest was awarded a contract to stand-up and implement the brand new Patient Centered Community Care (PC3) program across 28 states and the Pacific. Initial access to specialty care from network providers began in January of 2014, with the rest of the program coming online over the months that followed.

PC3 was intended to be a nationwide program giving VA Medical Centers (VAMC) an efficient and consistent way to provide access to care for Veterans from a network of credentialed providers in the community. We are pleased to be sharing this work in support of VA with our

long-time colleagues in the TRICARE work, Health Net. And, I want to assure this Committee that we are working together very collaboratively to leverage our collective knowledge so that VA benefits from it as they and you seek to fashion strategies that will optimize VA's direct delivery system and supplement that care with access to care in the private sector when and where it is needed.

Important to the success of PC3 was that the cost to VA, quality, and processes would be consistent all across the country. Community providers, VA staff, and Veterans would know how the program works. Congress and VA health care executives could more accurately budget for non-VA care costs. The facilities could turn to consolidated networks, tailored to their needs just like DoD did with TRICARE, versus inconsistently buying on their own. And, claims payment challenges for providers would be a thing of the past.

The promise of that vision is still there today.

However, the implementation of PC3 was not without challenges. And, overcoming those challenges has been a huge focus for TriWest and our VA partners during the first year of its operations.

For those of us at TriWest, a big challenge at the outset was the absence of data showing the VAMC's needs and historical purchasing patterns. As you might expect, it is very difficult to build a network of providers when you don't know the volume, configuration or location of demand. This led to some initial mismatches in our network and significant unexpected cost as we had to recalibrate the network once we received the needed information. Put simply, we had more of some services than VA would ever need in some places. But, we also had less of some services in other places than it turns out VA needs in order to ensure that care is both in sufficient supply to meet the need and reasonably close to where the Veterans reside. I want to compliment our contracting officer, Mara Wild, for tirelessly staying on the pursuit of this critical information over the course of nine months… information that we are putting to good use in our efforts to optimally calibrate the networks to meet the need.

Being able to effectively project volumes based on solid information not only assists with making sure that networks are tailored properly to support each VAMC and Community-Based Outpatient Clinic (CBOC), and the Veterans who rely on them for care, it also ensures that we have the staff necessary to administer the program and meet the tight performance specifications. The PC3 contract is designed to pay us only after care is ordered, appointments are made, the medical documentation is returned to VA to be inserted in the Veteran's consolidated medical record, and we have paid the provider. That means staffing levels are all at risk to us. If we hire too many staff and VA does not use the program, we lose money... effectively paying the government for the privilege of doing the work. But, if we hire too few, it can lead to delays in the receipt of care as we struggle to meet demand. So obviously, getting this as close to right as possible is very important.

There are few programs structured this way, as even TRICARE, Medicare plans, and private insurance have premiums being paid in advance to cover both the anticipated administrative costs and the projected health care risk.

Yet another challenge has been voluntary utilization of the PC3 program by each VA medical facility. As noted above, my colleagues and I at TriWest and our owners who call most of the communities in our area of operation home, built a network of providers based in part on estimates derived from historical fee basis care purchasing. However, much to our surprise, we've painfully discovered that many facilities have simply continued to use, almost exclusively, their historical non-VA care program to buy care from community providers… even when we had network providers. In fact, some of our network providers were the same providers from whom they continued to buy directly. While some VAMCs have largely abandoned this practice, we have had a very difficult time understanding why this practice has been allowed to continue such that only about 15% of total purchased care has been bought through this mechanism and VCP, in spite of all the money and man hours that have been spent in constructing these networks.

Beyond that, we see provider confusion as we attempt to convince them to join a network when they are already seeing Veterans through the legacy programs. Even worse, when a provider does join the TriWest network but continues to receive referrals for services from both VA and TriWest, they quickly notice that the requirements, rates, and claims processes are often completely different. And yet, to the provider, it is a Veteran being referred for care by VA.

Voluntary utilization of PC3 at the local level has also exacerbated the challenges with staffing because even when utilization data is available, we cannot assume such workload will come through the contract. We have to consider how much volume each local medical facility will move through the networks, and its related processes, as we determine how much staff is needed to do the work. And, as you might expect, those projections are extremely difficult to make with any accuracy… even with the talented and experienced staff we have attending to that task.

There is, however, hope. I would like to compliment my fellow panel member, Dr. Jim Tuchschmidt, for the direction that he and the rest of VA's leadership have given to the team at VA that this practice is to come to a halt. Instead, their direction is that the networks that were constructed to support them and programs, such as VCP, which extend options further for Veterans, are to be used rather than resorting to direct purchasing of care.

Mr. Chairman, fortunately, the first year of PC3 operations has also had a lot of successes. In fact, I'd say that in spite of the challenges I've just noted, we have made some amazing progress together in a very short span of time.

The most important element of that progress is that more workload is coming through this contract than when it started. In January 2014, the first month of operations for PC3, TriWest

received approximately 2,500 requests for care. This past April, we received over 21,000. As I just noted, whether to use the contract is still seen as voluntary throughout the system. So, when more care comes through the contract, it is evidence that more VAMCs see the benefits of using consistent processes, rates, and network to obtain needed, quality care for Veterans. In the long run, when these programs are the vehicle for the vast majority of care purchased outside of VA, the consistency will benefit the entirety of the non-VA care program.

Concurrent with, and certainly not unrelated to the growth in utilization, the partnership between VA and TriWest has matured substantially over the past year. And that maturity has helped us to focus on better matching the needs of local Veterans with the providers in the network, and ensuring those providers are in the right communities served by the VAMC. For example, while it is important to know that the Topeka VAMC purchased 500 MRIs from community providers in a given month, it is critical to know if they purchased 200 in Manhattan, 100 in Hays, and 200 from Salina… as they are all considered to be in the catchment area of the VAMC. However, as I am sure Senator Moran can attest to, the Topeka Kansas VAMC has a big catchment area in a huge state. Without that second layer of data, TriWest would almost assuredly build network in the wrong places.

The work we are doing at each other's side, and the appreciation of what is needed for us to execute with reasonable effectiveness for VA in support of Veterans is allowing us to grow the provider network smartly. One year ago, there were just over 50,000 network providers serving VAMCs in Regions 3, 5, and 6. Today, we've crossed the threshold of 100,000 providers in the network devoted to caring for Veterans in need of services from providers in their community. More of those providers are in more communities where the needs exist. And we aren't done yet, which I will talk about in a few minutes.

It is also important to make sure when you ask a provider to render care that they get paid on time and accurately for their work. Not only is it proper, but that is the way to ensure they are likely to agree to serve another Veteran when the need arises. As we all know, when you have to spend time chasing the bill payer, it adds to expense and makes the work less attractive. And, we want this work to be attractive… just as it was with TRICARE when we worked to help the DoD reengineer claims processing at the start of the program which put us on a path to becoming the fastest and most accurate payer with which most of our provider network dealt.

Any new program has challenges with aspects of implementation and operation. And, unfortunately, at the outset of PC3, we were not paying our claims as quickly as we would like. In fact, I think we were averaging close to 90 days in June of 2014. That simply isn't the case any longer. Experience, focus, and refinements have successfully brought us to a place where our average clean claim is now being paid in fewer than 30 days. Providers who render quality care to our Veterans deserve timely payment of their claims. And we are committed to honoring their service at our side by doing just that.

On the way to improving the PC3 experience for Veterans, VA, and providers, it turns out that we also were just getting warmed up in preparation for the ultimate program implementation run which came in October of 2014 with the first indication that the new VCP would become a modification to the PC3 contract. And, the intensity was about to pick up several-fold.

Implementing the Veterans Choice Program

To be exact, we would ultimately have one month for the implementation of this massive new program that would "go live" on November 5, 2014.

I recall vividly that during one of the initial discussion sessions VA had with potential industry partners in mid-September 2014, it was said by some in the room that 12-18 months was the needed timeframe in which to stand up a program of this magnitude. And while there certainly were imperfections on Day 1, and we continue to refine operational processes internally at TriWest and between VA and us, I'm very proud of what we all accomplished in such a short timeframe. And I would like to focus for a moment on what went right, before I share with the Committee what remains a challenge and what I hope we all can focus on for the future as we seek to achieve an effective and efficient program for those we are all privileged to serve.

As this Committee is aware, the law mandated that all Veterans enrolled for care with the VA Health Care system as of August 1, 2014 receive a Veterans Choice Card. At its core, this required printing those cards and mailing them off to Veterans. But, in reality, it involved so much more.

First, we had to partner with VA to receive a list of all Veterans eligible to receive the card. We were informed early on that the list would contain nearly nine million names. Of course, in order to ensure that a list of that size can be used for its intended purpose, formatting is crucial. Working together with VA and our colleagues at Health Net, we agreed on a template of the fields that would be provided to us. We then made that template available to the card printer we selected once the design was available to us because they had a week to get the first batch of cards printed, stuffed, and into the mail.

At the same time, we worked with our colleagues at Health Net to parse out all of that data and break it up so that each of us would have the right list of Veterans for each area served. After completing that project, we knew there were just under four million Veterans eligible in the area of our responsibility.

Just knowing who was to receive a card was not enough. We also had to load all of that data into our customer relations management (CRM) system so that when those cards arrived in the mail and Veterans called the number on the back, we knew who those Veterans were when we answered the phone. And I'm proud to say that we had that system up and operational in advance of "go live" day.

While we are on the topic of phones, at the same time all of the data loading and print work were occurring, we were also standing up a call center infrastructure big enough to serve the outreach from all of those who would receive the cards as well as providers and others in the general public who learned about the new benefit and had questions.

To accomplish this task, we worked directly with Verizon and our call center partner to establish a cloud-based system that would support a single, public-facing phone number (866-606-8198) where a Veteran; a provider; or a VA staff member encountered a message from the Secretary about the program and then was routed to the appropriate agent representing us based on their zip code to receive supportive services. Again, in fewer than 30 days, we designed and stood this up and it was staffed with nearly 800 people by November 4, 2014 so that we would be ready to serve Veterans in need.

I would submit that our most important accomplishment is what did not happen. No computers crashed. No busy signals occurred. In fact, there were no long waits for the phone to be answered by a live person. In less than 30 days, working together with VA and other partners, we stood-up a contact center that worked.

In those first 30 days, we also had to work with VA to develop a means of learning who was eligible for VCP at any given time. As you know, the law created two distinct types of eligible Veterans: those waiting longer than 30 days to receive needed care; and those residing more than 40 miles from the closest medical facility of the department. TriWest would need to know which Veterans qualified under which category of eligibility because the range of services available differs greatly.

Those residing more than 40 miles from the closest VA medical facility are eligible to receive through VCP any needed medical care covered by VA. TriWest is delegated responsibility to make determinations of medical necessity. As such, our only issues in serving this population are whether the care is medically needed, and whether there is a provider close-by who agrees to provide that service. As many members of this Committee know, if you live more than 40 miles from the closest VA medical facility, it is likely you live in a rural or highly rural area. As such, it is often not only VA that is far away, but it can be difficult to locate some types of specialty and subspecialty providers due to their scarce supply.

For the 30-day waitlist population, the task proved much more difficult because it was not only necessary to know that you were on the eligibility list, but we needed to understand what service(s) the Veteran needed. For this, we would need clinical information (known as a “clinical consult”) from the referring VA provider.

In an effort to expedite the provision of that clinical information, given the very short time in which to stand this up, an initial decision was made by VA leaders to send us all clinical consults related to any Veteran on the Veterans Choice List (VCL). The initial waitlist alone contained

information on over 34,009 Veterans. For each of those names, we would also receive via fax information documenting their respective clinical need. Then, we had to match that clinical information with the registry created by the card-mailing file and the updates created by the eligibility file so that we could help Veterans in need of service when they called. This process has proven to cause the most challenges in operation of VCP.

Nevertheless, in the six months the program has been operational, TriWest has processed over 40,000 authorizations for care. And we have seen growth in the use of the program every month with the exception of a slight drop between January and February of this year. In November 2014, we processed approximately 2,600 authorizations (more than the first month of operation under PC3). By April 2015, the number was 10,600; growth of nearly 400%.

As I mentioned earlier, while we certainly had many successes about which I am proud, I am by no means suggesting that all went right in our implementation. And I think it is very important that we outline what went wrong if for no other reason than because Veterans and their representatives in Congress deserve to know and understand our challenges. After all, at the end of the day, we are ever mindful that we are all spending taxpayer money.

First, and foremost, we suffered from a lack of training time. We had less than two weeks to hire and train hundreds of people just to answer phone calls from Veterans and describe or explain a complex new program. It is no understatement to say that most who worked to get VCP up and operational worked 100 hour weeks during that 30-day period… in order to understand what was envisioned by the law and then design the approach and stand-up operations. Given the brief amount of time to do all that was required, one of the greatest challenges was to gain a solid base of understanding of this valuable new benefit, and get the operation design set so that we could sufficiently explain both to others. And, we were not alone in that challenge. Among those most impacted, beyond the Veterans we were all aiming to serve, were the new staff in the call centers, as they only had five to seven days in which to grasp the information versus the typical two to three week period one ought to provide. I am sure others, including VA, struggled with the same.

Obviously, the lack of training led to less than optimal customer experiences. Information provided to Veterans was at times inaccurate or confusing. And some Veterans were left frustrated. I want to apologize for that. But, in apologizing, I also want to assure this Committee that we did everything in our power to train and educate this new team in the very short period of time we were allotted. In the end, it was simply not enough time. And, we are doing our best to stay on top of making sure that our staff has the right knowledge base of the program in order to provide solid customer service… even as this program continues to be refined, creating a need for re-training.

The training of our staff was not the only challenge that impacted the customer service experienced by Veterans who called the Choice line. As noted above, there are many areas where

cooperation and collaboration between VA and TriWest needs to occur every day to ensure solid performance of VCP. I think it is fair to say that as hard as it was for TriWest to train hundreds of new staff, it is vastly more complicated for VA's leadership to train thousands – maybe even tens of thousands – of administrative and scheduling staff all across the United States so that their engagement with Veterans would be informed. Not only that, but this challenge left us in a place where our staff and Veterans struggled with the impact of encounters with insufficiently trained personnel on whom they had to rely for information in order to achieve a positive customer experience.

Another challenge in early implementation of VCP was the timely receipt of the eligibility file. As I mentioned earlier, VA worked with us to create a template that would allow their team in the Eligibility Office to push regular information to us about which Veterans were eligible for VCP. But, the Eligibility Office also needed to obtain that information every day from clinics all across the country. It was always the goal to provide a new file every night so that when a Veteran called us the next day, we knew of their eligibility. In reality, even to this day, there is at least a five-day lag in between when a Veteran is told there is a wait time in the clinic that provides them eligibility for VCP and when that information can be used by TriWest to serve the Veteran.

There are many reasons for this delay. But, none of them are related to a lack of hard work. In fact, I would like to publicly acknowledge the incredible work done by Laura Prietula and her team in the Eligibility Office. She is a dedicated public servant who seeks to deliver outstanding work every day and from our experience many nights she is there too. And, there are many others like her in VA working tirelessly in an attempt to get this benefit to where we all want it to be. The hope is that some level of automation is coming to this program and to this area in particular. But, it was not available on Day 1 and that has led to some challenges and frustration.

Still another challenge has been the receipt of the clinical consultation information from VA which, as noted earlier, is necessary to schedule an appointment with a provider. For those eligible for VCP by virtue of their inclusion on the 30-day waitlist, TriWest must have a clinical consult for use when helping to make an appointment. The information in the consult tells the provider in the community why the Veteran is being referred to them for services. Providing this information is standard practice and good clinical care. And for some services, it is even required by Medicare, insurance policies or other accrediting organizations. For example, no imaging center will provide an MRI, CT, or other sophisticated imaging study without a physician order. This order would be in the clinical consult.

Because this information comes from hundreds of different clinics all across the VA system, receipt of that information in a consistent fashion has been a challenge. Without it, however, we are left with no alternative but to tell a Veteran who calls the Choice line that we are waiting on

clinical information from VA. Needless to say, when we tell a Veteran we know they are eligible, and yet we still cannot help them, the frustration is enormous.

As I noted above, the consult is supposed to come to TriWest automatically for every Veteran who is placed on the VCL. Unfortunately, we only know what we don't have when a Veteran calls for an appointment and can't receive one. I also do not want to lay all of the challenges in this area at VA's feet. The fact is, many times when we call for consults that we do not believe we have, we are told by VA staff that they were already sent. This no doubt frustrates VA staff too.

The good news is that recently we implemented a pilot program in VISN 17 in collaboration with the Dallas VAMC which is testing whether a process of requesting on our end can be met with a response on VA's end within 24 hours. Initial data suggests that it is working well. If the evidence continues to show promise, it will mean that Veterans all across the country can expect a consistent customer experience under which we can all assure them that we will have the information necessary to make an appointment within 24 hours of them calling us. And no longer will VA be responsible for sending thousands of clinical consults every day for Veterans who may not use VCP. I would submit that this is a win-win.

This looming success in addressing one of our collective challenges flows from the collaborative work in which we, Health Net and VA have been engaged since the beginning of the year. Just a little over 60 days from the start of VCP, we began to sit down together to map the gaps in process and customer service and blueprint how to resolve them. The focus of this work is to identify the components of our individual and collective work, or the policies and approaches that underlie them, that are in need of re-engineering or refinement to ensure that Veterans receive the access to care that was envisioned with the enactment of VCP.

This work is highly collaborative and involves leadership at all levels of the three organizations. In fact, just last week we all met for a day-long summit on Clinical Issues where we identified problems, discussed solutions and made the changes that will close gaps. This was on the heels of our regular, monthly day-long summit during which we focus on needed administrative process changes or refinements. Those issues are brought to the table by a myriad of integrated topical workgroups that meet in many cases several times a week.

It is intense and focused, just as should be… as we are trying to quickly address the processes we all know need attention in order to improve this critical program and meet the intended objective of VCP.

I would submit that this approach is yielding effective change and refinement at great speed for a program of this magnitude that was stood up very quickly and across a vast geographic expanse. And, I want to offer that the focus and intensity on the part of those involved and the

collaboration present is unlike anything I have ever seen in my 30 years of engagement in this space.

For our part, not only are we engaged at a macro level, but we are operating in this same fashion within our company… which is how we have accomplished successful and quick refinement and improvement since the early days of TRICARE nearly 20 years ago. We have also engaged our long-time partner in such work, the world-renowned Customer Service Institute at Arizona State University, to conduct customer service gapping and blueprinting with the Phoenix VA and within our own organization.

The very early indications are that this time-tested approach, mirroring that of the most highly regarded customer service brands in America, is beginning to yield results that matter.

The customer experience under VCP is getting better with each passing day. Information provided by TriWest staff is more consistent and more accurate; providers are more familiar with the program; and we have recently begun an initiative that allows any provider in our region to register online with us to be a VCP provider. Knowing who is willing to treat a Veteran under VCP, even if they are not already a TriWest network provider, will go a long way towards speeding up the appointing process.

Additionally, we are updating our entire CRM system so that our staff and all of the VA staff across our regions who interact with us in the IT environment will have more information about each Veteran right at their fingertips. Construction of these brand new tools was conceived of through the collaborative process of which I just spoke. We have condensed design and testing of these new systems to weeks and are using a 24/7 build strategy in order to rollout the new tools just after Memorial Day rather than waiting until next year, which would be the case using normal construction schedules.

It has been my experience that many customer service failures are due to the fact that line staff (those on the phone or on the ground) simply do not have access to the information needed to help a customer. When information is available, resolution of problems is possible. This new effort and these new tools will lead us down that road.

That said, there are many improvements needed that will require longer-term planning, collaboration, and perhaps even legislative change to what you passed last Summer. And I would like to take a moment to discuss a few of those and how, if they are pursued, VCP and PC3 can help bring an entirely better experience to the Veteran in need of health care services.

Refining the Veterans Choice Program for the Future

One area I would respectfully suggest is in need of review is the 60-day authorization limitation in the VACAA statute. While we understand there were reasons to include the time duration

limitation, I would respectfully suggest that it is leading to an increasing number of circumstances where quality and continuity of care are not the ultimate determining factors in the treatment of a Veteran. As a quick example, under the strictures of the statute, a Veteran sent through VCP for radiation oncology services because the local VA could not see him or her within 30 days, could have that service "recaptured" by VA after the first 60 days in the community if the local VA now has capacity. I am not a clinician. But, my Chief Medical Officer tells me that only under extreme circumstances should you change radiation oncology services in the middle of treatment. Yet, we understand that the statute leaves no alternative to continue that care through VCP.

The same circumstance would apply to maternity care. If the initial appointment was more than 30 days out, a female Veteran could be sent through VCP to a community OB/GYN. However, after 60 days, VA would have to reassess their capacity and could recapture the care, requiring the Veteran to change provider mid-pregnancy. Again, I know there were reasons for the requirement. However, I would respectfully suggest a revaluation to allow for some flexibility when it is in the best interests of the patient.

Additionally, I would respectfully suggest that there is a need to harmonize all of the disparate programs that now exist to provide non-VA (or community) services to Veterans. I noted earlier that voluntary use of the PC3 contract made it difficult to predict with any reasonable accuracy how much network would be needed for certain services and where that network was needed. It is also true that even if I can accurately predict network needs, it is difficult to convince providers to join a network when they already receive work directly from VA at better rates with fewer requirements. It sounds odd to say, but in some instances we're competing against VA to provide services to VA. Harmonizing the programs in some manner would help alleviate this challenge.

I also mentioned that without knowing, generally, the overall volume of services VA will need from my company, it is difficult to staff accurately for workload. But, again, it is difficult to predict workload when local facilities simply have options every day on the program through which they intend to purchase services.

I think the net result of both of these challenges that stem in some manner from multiple different programs come through loud and clear in the recent IG report which found a lack of savings under the initial year of the PC3 program. The IG noted that there were instances in which timely appointing wasn't available through TriWest or network providers were not close by. While I do not know the exact cases the IG reviewed, I know it is true that when workload exceeds our imperfect projections we find ourselves with inadequate network and a lack of staff. And that will lead to delays in appointing and difficulties finding providers. As an aside, I might note in response to another aspect of the IG report, that measuring first year savings of the PC3

program against implementation fees designed to cover five years of operations is a little bit of apples-to-oranges comparison.

Nevertheless, I am pleased to say that I understand VA intends to take some steps to create a hierarchy of options that local non-VA care staff will be expected to follow. This will go a long way towards providing everyone: VA staff, Veterans, community clinicians, and my team with the information we all need to bring timely care to Veterans using a consistent process with predictable rates.

This new effort on VA's part does lead me to one additional observation on what is needed for the long-term health of these programs. We must focus on a better collaborative planning process when changes are needed.

I've noted at length the challenges we experienced in implementing VCP; partly due to the short implementation schedule. Yet, just in the last few weeks, we saw an implementation of VA's new determination on eligibility under the 40-mile rule. I want to be clear and say that this is a tremendous change for Veterans. It is absolutely true that one of the most frequent complaints to our call center was the "crow flies" determination. However, there were only three weeks between the time it was determined that the rule would change and when VA sent out letters to just over 128,000 Veterans in our three regions notifying them of this change.

In just the first week following the letter, workload to our call center for VCP more than doubled. And, we understand that there are likely additional changes coming as well that VA is working on.

The challenge will be to synchronize them effectively so that we have the best chance to make sure that sufficient staff are hired and trained to meet the increased demand, or to agree among all effected that the change needs to be made quicker and that it is acceptable for capacity to catch up to demand.

Regardless, we are "All In"!

One of the areas I know that is being worked diligently within VA is how to ensure that the networks we are constructing and the providers who want to serve at our side in support of Veterans are being utilized. And, that is to be applauded.

The Art of the Possible

At the ground level, I am thrilled at the strong collaboration that is emerging all across our geographic area of responsibility. It is being supported by one of the superstars from our area, Joe Dalpiaz, as he is taking his time to completely engage at the side of his colleagues and me to fashion the "art of the possible".

We started with one of the largest facilities in the VA system, which is under his engaged and watchful eye, and sat down with the Director and non-VA care team to look at all of the demand they have for community services and where the VA's needs are. Then, we produced an assessment of whether the network we have built is sufficient to meet VA's full demand. Where a bit more service is needed, we are discussing the optimal strategy to bring it to a fully tailored state so that Veterans in that community will have exactly what they need, when they need it … whether it is from a VA medical facility or with a community provider. Of course, a Veteran will also be free to select a provider of their choice to the degree that one does not exist within VA or the network.

This effort includes primary care and specialty care, to include behavioral health. And, I am confident of the success that will come from this completely engaged and collaborative effort, which will have each leader within VA knowing what they have at their disposal inside VA and in the community to meet the access needs of Veterans…

My confidence in this process is bolstered by the fact that this is exactly what we did together with DoD in TRICARE that led to phenomenal success in our area of responsibility and it is what we have now accomplished together with the VA leaders in Phoenix and Hawaii… where networks are now completely tailored to demand. These early successes were the result of the great collaborative effort involving not only the local leaders and staff, but the tireless work of several in VA: Sheila Cain, Greg Frias and Tommy Driskill.

We have prioritized the areas in which we will begin this work in collaboration with the VA leaders that Joe and I have met with over the last five weeks. This ensures that we can quickly move the needle once VA communicates its intention to the provider community that VCP is the pathway, and ensures its own staff on the ground is lined up behind the objective of this being the purchasing tool for care when it is unavailable in VA, or from a nearby DoD facility or academic affiliate.

For the purpose of illustration, I would like to highlight what will come from this as it relates to one of the biggest needs at the moment… timely and convenient access to behavioral health care.

To be sure, VA is the gold standard in understanding the behavioral health needs of our Veterans. But, there are many instances in which we may be able to help them free up space in VA for their most acute patients by working with providers in the community.

Next, I am matching that demand (both behavioral health and all other services) against the network we have in the catchment area of the VAMC. And I am doing that in a fully transparent way right in front of the VAMC Director. Where I have what he needs, he will know it. And he will also know what I am missing.

Next, the VAMC Director will begin notifying local providers that he will be sending all of his community care through PC3 and VCP and there will no longer be (with few exceptions) local, direct contracts. Then, my team will set out on an aggressive schedule to build the network that can fill in the gaps identified by the "map-and-gap" analysis. Community providers will know that VA's future purchasing will be through the consolidated network. We will provide regular updates to the team at the VAMC. And as network growth occurs, so too will workload, which means I can plan for the hiring and training of staff on a timeline to deliver.

In the very long run, VAMCs can use this process to analyze "make/buy" decisions. Obviously, there is a tremendous need for many services at VA medical facilities. But, there are also many exigent circumstances that VA must confront in every community. Internal VA expansion may be desirable and justifiable. However, perhaps the physical space does not exist; the facility may be landlocked; or, most commonly, the community itself has a shortage of the type of providers VA requires to meet the needs of Veterans, which makes direct hiring difficult.

In those instances, it is my hope that they will find a robust network to be an asset they can use in planning and delivering. Perhaps the marginal use of time from a dozen community providers can better meet the needs of the Veterans than hiring one internally because of some challenges I've just mentioned. And, perhaps hiring directly is the right thing to do. That decision should always rest with VA and Congress.

To be clear, I am not suggesting in any way that PC3 or VCP should replace the direct care provided by the VA health care system. But, I do believe that greater knowledge of what is available locally from a network of providers could help VA in the long run plan for and deliver quality health care in a more timely fashion.

I believe that is what you envisioned in the passage of VCP… and, I believe the successful fulfillment of that vision in support of those who have borne a high cost in defense of freedom is very much the "art of the possible." We look forward to doing our part as you refine and modify policies and authorities to give us the final tools that will be needed to accomplish the success that we all desire.

Conclusion

Mr. Chairman and members of the Committee, my colleagues and I at TriWest truly believe that if we are transparent about the needs and the shortcomings, collaborate together with VA to fill the gaps, and then implement them as quickly as possible, we will earn the trust of Veterans and collectively meet their needs. And believe me, I know we must earn this trust.

Supporting the care needs of America's Veterans is a tremendous honor and privilege for me, all of the employees of TriWest, our non-profit owners, and most importantly the providers in our markets that have leaned forward at our side to say we will serve a few of our fellow citizens

when they have needs that are unable to be met by VA directly. We are humbled by the service and sacrifice of America's Veterans and their example reminds us constantly of the high cost of freedom. We take our responsibility very seriously and VA, Veterans, and this Committee can be sure that our entire focus is on ensuring that our work in support of VA and the Veterans who rely on them for their care is fitting of the sacrifices of our heroes and is worthy of their trust.

This concludes my formal testimony. I'd be happy to answer any questions you might have.